FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040592

Facility Name: CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER

Address: 3400 S. INDIANA (Number) CHICAGO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (312)842-5000 **Fax #** (312)842-3790

IDPA ID Number: 36-3964686-001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD SGARLATA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	322	Skilled (SNF)	322	117,852	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	322	TOTALS	322	117,852	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	97,476	1,899	7,126	106,501	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	97,476	1,899	7,126	106,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.37%

D. How many bed-hold days during this year were paid by Public Aid? 3,295 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 41 and days of care provided 5,130

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHA # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,502	118,842	11,104	457,448		457,448		457,448			1
2	Food Purchase		429,417		429,417	(57,316)	372,101	(204)	371,898			2
3	Housekeeping		15,056	530,281	545,337		545,337		545,337			3
4	Laundry		27,940		27,940		27,940		27,940			4
5	Heat and Other Utilities			255,467	255,467		255,467	460	255,927			5
6	Maintenance	86,729	35,462	95,628	217,819		217,819	1,976	219,795			6
7	Other (specify):*							(29)	(29)			7
8	**TOTAL General Services**	414,231	626,717	892,480	1,933,428	(57,316)	1,876,112	2,203	1,878,316			8
	B. Health Care and Programs											
9	Medical Director			32,910	32,910		32,910		32,910			9
10	Nursing and Medical Records	3,002,694	178,536	10,858	3,192,088		3,192,088	(12,635)	3,179,453			10
10a	Therapy	56,454		7,750	64,204		64,204		64,204			10a
11	Activities	113,671	12,232	1,780	127,683		127,683		127,683			11
12	Social Services	119,179		2,975	122,154		122,154		122,154			12
13	Nurse Aide Training	5,481		1,486	6,967		6,967		6,967			13
14	Program Transportation			2,485	2,485		2,485	2,673	5,158			14
15	Other (specify):*							272	272			15
16	**TOTAL Health Care and Programs**	3,297,479	190,768	60,244	3,548,491		3,548,491	(9,690)	3,538,801			16
	C. General Administration											
17	Administrative	181,566		824,122	1,005,688		1,005,688	(641,362)	364,326			17
18	Directors Fees											18
19	Professional Services			153,991	153,991		153,991	2,810	156,801			19
20	Dues, Fees, Subscriptions & Promotions			120,731	120,731		120,731	(59,790)	60,941			20
21	Clerical & General Office Expenses	222,176	55,871	85,803	363,850		363,850	155,098	518,948			21
22	Employee Benefits & Payroll Taxes			674,209	674,209	57,316	731,525		731,525			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,121	5,121		5,121	1,498	6,619			24
25	Other Admin. Staff Transportation			13,627	13,627		13,627	(10,970)	2,657			25
26	Insurance-Prop.Liab.Malpractice			162,312	162,312		162,312	364	162,676			26
27	Other (specify):*							37,994	37,994			27
28	**TOTAL General Administration**	403,742	55,871	2,039,916	2,499,529	57,316	2,556,845	(514,358)	2,042,487			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,115,452	873,356	2,992,640	7,981,448		7,981,448	(521,845)	7,459,603			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER
0040592
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	57,316	
2	FOOD		57,316

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING C #0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			129,205	129,205		129,205	(27,666)	101,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92,090	92,090		92,090	1,098,619	1,190,709			32
33	Real Estate Taxes			448,845	448,845		448,845		448,845			33
34	Rent-Facility & Grounds			1,772,689	1,772,689		1,772,689	(1,758,454)	14,235			34
35	Rent-Equipment & Vehicles			12,602	12,602		12,602	11,777	24,379			35
36	Other (specify):*			9,312	9,312		9,312		9,312			36
37	**TOTAL Ownership**			2,464,743	2,464,743		2,464,743	(675,724)	1,789,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,394	187,621	255,322	458,337		458,337	47	458,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,778	176,778		176,778		176,778			42
43	Other (specify):*	41,822			41,822		41,822	(41,822)				43
44	**TOTAL Special Cost Centers**	57,216	187,621	432,100	676,937		676,937	(41,775)	635,162			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,172,668	1,060,977	5,889,483	11,123,128		11,123,128	(1,239,343)	9,883,785			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,183)	30		9
10	Interest and Other Investment Income	(1,665)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(929)	21		18
19	Entertainment	(11,706)	25		19
20	Contributions	(14,800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,465)	21		24
25	Fund Raising, Advertising and Promotional	(46,315)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,315)	20		28
29	Other-Attach Schedule	(59,269)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (222,724)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,016,620)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,016,620)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,239,343)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER

ID# 0040592

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Marketing Salary	(41,822)	43	2
3	Veteran's Pharmacy	(14,002)	10	3
4	C.O.P.E.	(519)	20	4
5	Legal - 1999 services	(680)	19	5
6	Replacement Tax	(3,192)	21	6
7	Misc. Income - Copying	(268)	21	7
8	Misc. Income - Jury Duty	(103)	10	8
9	Misc. Income - Telephone	(313)	21	9
10	Misc. Income - Food Rebate	(127)	2	10
11	Misc. Income - Gas	(743)	5	11
12	Equipment Rental	2,500	35	12
13				13
14				14
15				15
16				16
17				17
18				18
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86				86
87				87
88				88
89				89
90	**Total**	(59,269)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(204)											(204)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(743)		1,203									460	5
6	Maintenance			1,976									1,976	6
7	Other (specify):*			(29)									(29)	7
8	**TOTAL General Services**	(947)		3,150									2,203	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(14,105)		1,470									(12,635)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			2,673									2,673	14
15	Other (specify):*			272									272	15
16	**TOTAL Health Care and Programs**	(14,105)		4,415									(9,690)	16
	C. General Administration													
17	Administrative			(776,238)	161,113	(26,237)							(641,362)	17
18	Directors Fees													18
19	Professional Services	(680)		2,967		523							2,810	19
20	Fees, Subscriptions & Promotions	(64,949)		4,251		908							(59,790)	20
21	Clerical & General Office Expenses	(54,167)		202,811		6,454							155,098	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,463		35							1,498	24
25	Other Admin. Staff Transportation	(11,706)		736									(10,970)	25
26	Insurance-Prop.Liab.Malpractice			364									364	26
27	Other (specify):*			29,657	4,573	3,764							37,994	27
28	**TOTAL General Administration**	(131,502)		(533,989)	165,686	(14,553)							(514,358)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(146,554)		(526,424)	165,686	(14,553)							(521,845)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING # 0040592 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(35,183)		7,517									(27,666)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,665)	1,103,806	(3,522)									1,098,619	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,772,689)	14,235									(1,758,454)	34
35	Rent-Equipment & Vehicles	2,500		9,277									11,777	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(34,348)	(668,883)	27,507									(675,724)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			47									47	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(41,822)											(41,822)	43
44	**TOTAL Special Cost Centers**	(41,822)		47									(41,775)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(222,724)	(668,883)	(498,870)	165,686	(14,553)							(1,239,343)	45

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				CHAVY CHASE ASS	CHICAGO	BLDG PARTNSHI

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST EXPENSE	$	CHEVY CHASE ASSOC.	100.00%	$ 1,103,806	$ 1,103,806	1
2	V	34	RENT	1,772,689	CHEVY CHASE ASSOC.	100.00%		(1,772,689)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,772,689			$ 1,103,806	$ * (668,883)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 1,203	$ 1,203	15
16	V	6	REPAIRS AND MAINT.				1,976	1,976	16
17	V	7	EMPLOYEE BEN. GEN. SERV.				(29)	(29)	17
18	V	10	NURSING ADMIN. COMP.				1,470	1,470	18
19	V	14	PROGRAM TRANSPORTATION				2,673	2,673	19
20	V	15	HEALTHCARE BENEFITS				272	272	20
21	V	19	PROFESSIONAL FEES				2,967	2,967	21
22	V	20	FEES SUBSCRIPTIONS				4,251	4,251	22
23	V	21	CLERICAL & GENERAL				202,811	202,811	23
24	V	24	SEMINARS AND EDUCATION				1,463	1,463	24
25	V	25	ADMIN. STAFF TRAVEL				736	736	25
26	V	26	INSURANCE				364	364	26
27	V	27	EMPLOYEE BEN. GEN. ADMIN.				29,657	29,657	27
28	V	30	DEPRECIATION				7,517	7,517	28
29	V	32	INTEREST EXPENSE				(3,522)	(3,522)	29
30	V	34	BUILDING RENT				14,235	14,235	30
31	V	35	EQUIPMENT RENTAL				9,277	9,277	31
32	V	39	ANCILLARY				47	47	32
33	V	0					0		33
34	V	0							34
35	V	17	MANAGEMENT FEES	776,238				(776,238)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 776,238			$ 277,368	$ * (498,870)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 126,160	$ 126,160	15
16	V	17	ADMIN. - B. CARR				27,028	27,028	16
17	V	17	ADMIN. - D. HARTMAN				7,925	7,925	17
18	V	17	ADMIN. - E. DICKMAN				0		18
19	V	27	EMP. BEN. - R. HARTMAN				2,674	2,674	19
20	V	27	EMP. BEN. - B. CARR				1,231	1,231	20
21	V	27	EMP. BEN. - D. HARTMAN				668	668	21
22	V	27	EMP. BEN. - E. DICKMAN				0		22
23	V	0					0		23
24	V	0							24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0							28
29	V	0							29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 165,686	$ * 165,686	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 21,647	$ 21,647	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		523	523	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		908	908	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		6,454	6,454	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK		35	35	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		3,764	3,764	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	47,884	CAREPATH HEALTH NETWORK		0	(47,884)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,884			$ 33,331	$ * (14,553)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS' COMPENSATION	$ 52,424	DIAMOND INSURANCE	20.00%	$ 52,424	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,424			$ 52,424	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CH # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HARTMAN	OWNER	ADMINISTRATIV	60.75	SEE ATTACHED	6.39	9.83	Alloc. Salary	$ 126,160	17-7	1
2	BARRY CARR	OWNER	ADMINISTRATIV	4.75	SEE ATTACHED	7	12.73	Alloc. Salary	27,028	17-7	2
3	DAVID HARTMAN	RELATIVE	ASST. ADMIN	0.00	SEE ATTACHED	7.6	16.89	Alloc. Salary	7,925	17-7	3
4	DAVID HARTMAN	RELATIVE	ASST. ADMIN	0.00	SEE ATTACHED	7.6	16.89	Sallary	25,526	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 186,639		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	634,333	8	$ 6,475	$	117,852	$ 1,203	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	634,333	8	10,636	(714)	117,852	1,976	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	634,333	8	(156)		117,852	(29)	3
4	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	634,333	8	7,912	6,671	117,852	1,470	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	634,333	8	14,386		117,852	2,673	5
6	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	634,333	8	1,462		117,852	272	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	634,333	8	15,970		117,852	2,967	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	634,333	8	22,883		117,852	4,251	8
9	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	634,333	8	1,091,620	894,249	117,852	202,811	9
10	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	634,333	8	7,875		117,852	1,463	10
11	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	634,333	8	3,960		117,852	736	11
12	26	INSURANCE	AVAIL. CENSUS DAYS	634,333	8	1,958		117,852	364	12
13	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	634,333	8	159,629		117,852	29,657	13
14	30	DEPRECIATION	AVAIL. CENSUS DAYS	634,333	8	40,461		117,852	7,517	14
15	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	634,333	8	(18,956)		117,852	(3,522)	15
16	34	BUILDING RENT	AVAIL. CENSUS DAYS	634,333	8	76,619		117,852	14,235	16
17	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	634,333	8	49,932		117,852	9,277	17
18	39	ANCILLARY	AVAIL. CENSUS DAYS	634,333	8	253	208	117,852	47	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,492,919	$ 900,414		$ 277,368	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	8	720,633	720,000	6	126,160	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40	8	154,447	151,667	7	27,028	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	12	8	12,200	12,000	8	7,925	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	3,500	3,500			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	8	15,274		6	2,674	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40	8	7,034		7	1,231	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	12	8	1,028		8	668	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	317				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,433	$ 887,167		$ 165,686	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	47,884	$ 21,647	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		47,884	523	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		47,884	908	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	47,884	6,454	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		47,884	35	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		47,884	3,764	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 33,331	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INSURANCE
Street Address: 40 SKOKIE BLVD - SUITE 105
City / State / Zip Code: NORTHBROOK, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIAMOND INSURANCE	DIRECT ALLOCATION			$	$		$ 52,424	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 52,424	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHA # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loan	X		Working Capital				1,000,000	Renewal			6
7	LaSalle Bank		X	Working Capital	Interest Only		As needed		7/1 annual	Prime + 1	92,090	7
8												8
9	TOTAL Facility Related						$	$ 1,000,000			$ 92,090	9
	B. Non-Facility Related*											
10	Supplemental Schedule										1,098,619	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,098,619	14
15	TOTALS (line 9+line14)						$	$ 1,000,000			$ 1,190,709	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (1,665)	1
2	Allocation from NuCare	X									(3,522)	2
3	Chevy Chase Assoc.	X									1,103,806	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,098,619	21

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	250,309	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	450,527	2
3. Under or (over) accrual (line 2 minus line 1).	$	200,218	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	248,627	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	448,845	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	412,937	8
	1996	423,097	9
	1997	447,169	10
	1998	455,106	11
	1999	450,527	12

2000 accrual = $452,053 * 1.05% = $474,655 - $226,028(3/01 prepayment) = $248,627

Line 2 Taxes Paid: 1999 2nd Installment $224,499

2000 1st Installment $226028

Total: $450,527

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,625 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	80,457	1984	$ 240,000	1
2					2
3	TOTALS	80,457		$ 240,000	3

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	322		1986	1977	$ 4,471,948	$	35	$	$	$ 1,674,039	4
5			1984	1984	92,611		25			49,503	5
6							35			38,128	6
7											7
8											8
	Improvement Type**										
9	Various			1994	17,938	460	20	897	437	5,516	9
10	Various			1995	20,890	974	20	1,044	70	5,791	10
11	REPAIR SPRINKLER			1996	1,762	45	20	88	43	374	11
12	INSTALL PIPES			1996	2,315	59	20	116	57	522	12
13	PA SYSTEM			1996	1,485	38	20	74	36	358	13
14	DRAPERIES			1996	5,693	146	20	285	139	1,306	14
15	WALL SCONCE			1996	3,708	95	20	185	90	833	15
16	RAILINGS			1996	6,075	156	20	304	148	1,444	16
17	REWIRE FOR COMPUTER			1996	2,732	70	20	137	67	559	17
18	SHELVES			1996	4,187	107	20	209	102	871	18
19	EMERGENCY GENER			1996	5,353	137	20	268	131	1,117	19
20	SPRAYER ATTACHMENT			1996	1,945	50	20	97	47	420	20
21	FREEZER DOOR			1996	2,135	55	20	107	52	446	21
22	SMOKEETER UNIT			1996	2,590	66	20	130	64	542	22
23	REMODEL LOUNGE			1996	35,238	904	20	1,762	858	7,635	23
24	PAGE 12-2 REP TOTALS				19,620			886	886	6,448	24
25	PAGE 12-1 REP TOTALS				154,093	290		6,642	6,352	104,948	25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				6,681	142		206	64	206	30
31	PAGE 12E TOTALS				109,523	1,547		3,196	1,649	3,943	31
32	PAGE 12D TOTALS				50,059	1,285		2,505	1,220	3,580	32
33	PAGE 12C TOTALS				337,146	9,310		16,859	7,549	21,883	33
34	PAGE 12B TOTALS				106,551	2,733		5,329	2,596	12,363	34
35	PAGE 12A TOTALS				85,676	2,254		4,315	2,061	14,268	35
36	TOTAL (lines 4 thru 35)				$ 5,547,954	$ 20,923		$ 45,641	$ 24,718	$ 1,957,043	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CCTV SYS			1996	7,813	200	20	391	191	1,760	9
10	PLUMBING REPAIR			1996	2,465	63	20	123	60	564	10
11	INSTALL TELEPHONE SY			1996	1,067	27	20	53	26	256	11
12	REBOLT DISCHARGE DOO			1996	1,042	27	20	52	25	221	12
13	GARBAGE DISPOSER			1997	1,970	51	20	99	48	338	13
14	PLUMBING			1997	5,618	144	20	281	137	913	14
15	COOLING TOWER			1997	21,257	545	20	1,063	518	4,252	15
16	TELEPHONE LINES			1997	1,098	28	20	55	27	206	16
17	AIR CURTAIN CABINET			1997	1,267	32	20	63	31	221	17
18	SMOKE DETECTOR			1997	618	16	20	31	15	119	18
19	NURSE CALL SYSTEM			1997	782	20	20	39	19	130	19
20	TELEPHONE EQUIPMENT			1997	602	75	20	60	(15)	200	20
21	GARBAGE DISPOSAL			1997	2,310	59	20	116	57	454	21
22	CCTV SYSTEM			1997	1,684	43	20	84	41	273	22
23	GARBAGE DISPOSAL			1997	877	22	20	44	22	150	23
24	SPRING HINGES			1997	2,039	52	20	102	50	340	24
25	CORAL GRANITE			1998	757	19	20	38	19	82	25
26	HANDRAIL & GUARDS			1998	2,159	55	20	108	53	252	26
27	INTERNAL WIRING			1998	1,992	51	20	100	49	267	27
28	HANDRAIL & GUARD			1998	7,203	185	20	360	175	780	28
29	ROOF REPAIR			1998	2,315	59	20	116	57	280	29
30	PARKING LOT REPAIR			1998	4,600	118	20	230	112	575	30
31	STEEL DOORS			1998	4,135	106	20	207	101	500	31
32	MONITORING SYSTEM			1998	3,282	84	20	164	80	396	32
33	GENERATOR REPAIR			1998	2,839	73	20	142	69	308	33
34	ROOM REPAIRS			1998	2,523	65	20	126	61	284	34
35	FLOORING			1998	1,362	35	20	68	33	147	35
36	TOTAL (lines 4 thru 35)				$ 85,676	$ 2,254		$ 4,315	$ 2,061	$ 14,268	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHT FIXTURES			1998	2,040	52	20	102	50	221	9
10	WALLPAPER			1998	19,913	511	20	996	485	2,158	10
11	EMERGENCY ELECTRICIT			1998	7,770	199	20	389	190	1,167	11
12	VERTICLE BLINDS			1998	716	18	20	36	18	96	12
13	CCTV SYSTEM			1998	1,320	34	20	66	32	198	13
14	2ND FLOOR-PAINT			1998	20,400	523	20	1,020	497	2,210	14
15	TELEPHONE LINES			1998	506	13	20	25	12	73	15
16	WALLPAPER-OFFICE			1998	2,870	74	20	144	70	396	16
17	WALL BORDERS			1998	613	16	20	31	15	70	17
18	CARPET & WALLCOVER			1998	6,838	175	20	342	167	912	18
19	FLOORING & BORDERS			1998	3,793	97	20	190	93	396	19
20	RECEPTION STATION			1998	5,675	146	20	284	138	592	20
21	WALLPAPER			1998	800	21	20	40	19	83	21
22	NURSES CALL SYS R&M			1998	698	18	20	35	17	102	22
23	CCTV SYSTEM R&M			1998	958	25	20	48	23	132	23
24	TELEPHONE LINES			1998	768	20	20	38	18	105	24
25	WALLPAPER			1998	1,114	29	20	56	27	121	25
26	CCTV SYSTEM			1998	1,405	36	20	70	34	169	26
27	WALLPAPER			1998	1,568	40	20	78	38	208	27
28	TELEPHONE LINES			1998	907	23	20	45	22	101	28
29	WALLPAPER			1998	5,825	149	20	291	142	679	29
30	TELEPHONE LINES			1998	502	13	20	25	12	56	30
31	CUBICLE CURTAIN			1998	11,272	289	20	564	275	1,316	31
32	CUBICLE CURTAINS			1998	1,297	33	20	65	32	141	32
33	RECEPTION STATION			1999	6,157	158	20	308	150	616	33
34	ALARM-LEGAL			1999	222	6	20	11	5	12	34
35	TELE LINE-RECEPTION			1999	604	15	20	30	15	33	35
36	TOTAL (lines 4 thru 35)				$ 106,551	$ 2,733		$ 5,329	$ 2,596	$ 12,363	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TELE LINE-DIETARY			1999	762	20	20	38	18	41	9
10	PUMP SHAFT			1999	450	12	20	23	11	25	10
11	PAGING SYSTEM			1999	759	19	20	38	19	54	11
12	NURSES CALL SYSTEM			1999	1,021	26	20	51	25	72	12
13	ALARM SYSTEM-1ST FLR			1999	1,146	29	20	57	28	105	13
14	SHOWER REPAIR			1999	1,278	33	20	64	31	75	14
15	WALLPAPER-2ND FLR			1999	10,885	279	20	544	265	1,088	15
16	CUBICLE TRACK			1999	282	7	20	14	7	27	16
17	CERAMIC TILE			1999	2,452	63	20	123	60	246	17
18	FIRE ALARM SYSTEM			1999	221,434	5,678	20	11,072	5,394	11,995	18
19	CURTAINS & DRAPES			1999	9,676	248	20	484	236	928	19
20	FIREPROOFING			1999	4,725	121	20	236	115	452	20
21	AIR BALANCE MODEL			1999	1,213	31	20	61	30	112	21
22	ALARM SYSTEM-2ND FLR			1999	1,146	29	20	57	28	105	22
23	WALLPAPER-PHASE II			1999	4,960	127	20	248	121	496	23
24	LIGHT FIXTURES			1999	676	17	20	34	17	68	24
25	CCTV SYSTEM			1999	751	19	20	38	19	41	25
26	INTERCOM SYSTEM			1999	744	19	20	37	18	68	26
27	CUBICLE CURTAINS			1999	24,451	627	20	1,223	596	1,631	27
28	UNDERGROUND TANK			1999	22,123	567	20	1,106	539	1,567	28
29	DRAPERIES			1999	474	12	20	24	12	34	29
30	LIGHT FIXTURES			1999	5,014	129	20	251	122	356	30
31	WALLPAPER			1999	1,187	30	20	59	29	84	31
32	ALARM SYSTEM			1999	255	7	20	13	6	16	32
33	DOORS & FRAMES			1999	1,086	28	20	54	26	63	33
34	PAINT,WALLPAPER BORD			1999		513	20		(513)	417	34
35	WALL COVERING &BORDE			1999	18,196	620	20	910	290	1,717	35
36	TOTAL (lines 4 thru 35)				$ 337,146	$ 9,310		$ 16,859	$ 7,549	$ 21,883	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TELEPHONE WIRING			1999	624	16	20	31	15	41	9
10	HEATER			1999	8,250	212	20	413	201	482	10
11	WINDOW TREATMENT			1999	895	23	20	45	22	56	11
12	BORDER			1999	747	19	20	37	18	46	12
13	CONTAINMENT BASIN			1999	2,430	62	20	122	60	163	13
14	ALARM-FLOWS & TAMPER			1999	3,240	83	20	162	79	216	14
15	TELEPHONE WIRING			1999	1,195	31	20	60	29	85	15
16	ELEVATOR DOOR			1999	5,850	150	20	293	143	317	16
17	CARPET			1999	369	9	20	18	9	21	17
18	TELEPHONE LINE-LAUND			1999	582	15	20	29	14	34	18
19	COVE BASE			1999	1,319	34	20	66	32	88	19
20	ALARM SYSTEM-3&4 FLR			1999	2,127	55	20	106	51	159	20
21	SMOKE DETECTORS			1999	2,580	66	20	129	63	172	21
22	ALARM-LEGAL			1999	135	3	20	7	4	8	22
23	ALARM-IDPH			1999	2,400	62	20	120	58	130	23
24	ROOM SIGNAGES			1999	1,182	30	20	59	29	103	24
25	BOILER			1999	2,517	65	20	126	61	252	25
26	HANDRAILS & BUMPER			1999	4,750	122	20	238	116	456	26
27	WINDOW TREATMENTS			1999	1,145	29	20	57	28	114	27
28	KITCHEN AMPLIFIER			1999	738	19	20	37	18	43	28
29	PAINTING			1999	1,234	32	20	62	30	109	29
30	PLUMBING			1999	740	19	20	37	18	71	30
31	TIME-WALK IN FREEZER			1999	671	17	20	34	17	40	31
32	TELEPHONE WIRING			1999	809	21	20	40	19	73	32
33	WATER TANKS			1999	500	13	20	25	12	27	33
34	UNDERGROUND TANK			1999	2,500	64	20	125	61	229	34
35	DRAPERY			1999	530	14	20	27	13	45	35
36	TOTAL (lines 4 thru 35)				$ 50,059	$ 1,285		$ 2,505	$ 1,220	$ 3,580	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABINETS			1999	25,600	656	20	1,280	624	2,027	9
10	REPAIR A/C SYSTEM			2000	1,387	14	20	29	15	29	10
11	WANDER GUARD SYSTEM			2000	11,180	275	20	559	284	559	11
12	FREIGHT-INV #18476			2000	123	2	20	4	2	4	12
13	INSTL ELEC PANEL DEV			2000	926	17	20	35	18	35	13
14	INST HOOKUP 4 DIAL M			2000	19,600	231	20	490	259	490	14
15	CORNER GUARDS			2000	116	2	20	5	3	5	15
16	REPL SPRINKLER HEADS			2000	560	11	20	23	12	23	16
17	SPRINKLER SYS REPAIR			2000	1,109	27	20	55	28	55	17
18	INSTALL ALARM SYSTEM			2000	1,233	23	20	47	24	47	18
19	INSTALL WIRELESS NUR			2000	3,238	10	20	27	17	27	19
20	SERV ON ALARM SYSTEM			2000	980	20	20	41	21	41	20
21	INSTALL ELEC STRIKER			2000	638	11	20	24	13	24	21
22	FIRE ALARM PANEL			2000	1,900	43	20	87	44	87	22
23	COUNTERS			2000	907	5	20	11	6	11	23
24	WINDOWS			2000	875	21	20	44	23	44	24
25	CCTV SYSTEM			2000	1,079	8	20	18	10	18	25
26	FIRE DAMPER CLEANING			2000	1,450	14	20	30	16	30	26
27	OVERBED FIXTURES			2000	3,888	4	20	16	12	16	27
28	SAFETY LOC SYSTEM			2000	16,200	52	20	135	83	135	28
29	82 OVERBED FIXTURES			2000	5,904	44	20	98	54	98	29
30	83 OVERBED FIXTURES			2000	5,976	32	20	75	43	75	30
31	ELEVATOR WORK			2000	586	4	20	10	6	10	31
32	ELEVATOR WORK			2000	1,300	1	20	5	4	5	32
33	FIRE ALARM REPAIR			2000	1,144	8	20	19	11	19	33
34	FIRE ALARMS			2000	632	3	20	8	5	8	34
35	TELEPHONE SYS SERV.			2000	992	9	20	21	12	21	35
36	TOTAL (lines 4 thru 35)				$ 109,523	$ 1,547		$ 3,196	$ 1,649	$ 3,943	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REBUILT HEAT EXCHANG			2000	1,598	15	20	33	18	33	9
10	TEMPORARY TANK RENTL			2000		45	20		(45)		10
11	PHONE WIRING			2000	867	6	20	14	8	14	11
12	IN HOUSE PAGING SYS			2000	3,511	71	20	147	76	147	12
13	LOCKS			2000	705	5	20	12	7	12	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,681	$ 142		$ 206	$ 64	$ 206	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NUCARE ALLOCATION			1997	856	22	20	43	21	138	9
10	NUCARE ALLOCATION			1998	749	19	20	38	19	92	10
11	NUCARE ALLOCATION			1999	1,051	236	20	53	(183)	75	11
12	NUCARE ALLOCATION			2000	1,277	13	20	28	15	28	12
13	IMPROVEMENTS			1980	8,303		8			8,303	13
14	IMPROVEMENTS			1981	1,872		8			1,872	14
15	IMPROVEMENTS			1982	5,523		15			5,523	15
16	IMPROVEMENTS			1983	1,550		15			1,550	16
17	IMPROVEMENTS			1984	3,664		15			3,664	17
18	IMPROVEMENTS			1984	1,398		10			1,398	18
19	IMPROVEMENTS			1985	2,312		18	128	128	2,024	19
20	IMPROVEMENTS			1985	22,188		19	1,168	1,168	17,762	20
21	IMPROVEMENTS			1986	8,802		19	463	463	6,632	21
22	HUMIDIFIER			1987	2,325		10			2,325	22
23	BOILER			1987	1,819		20	91	91	1,251	23
24	HEAT PUMP			1987	1,007		15	67	67	888	24
25	DOOR LOCKS			1988	2,970		15	198	198	2,558	25
26	NURSES STATION			1988	2,217		20	111	111	1,434	26
27	ANTENNA/PA SYSTEM			1988	1,426		15	95	95	1,219	27
28	CONTER TOP			1988	6,652		20	333	333	4,051	28
29	SUMP PUMP			1988	1,107		25	74	74	943	29
30	LEASEHOLD			1989	12,710		25	636	636	7,314	30
31	ROOFING			1989	43,000		15	2,150	2,150	24,725	31
32	IMPROVEMENTS			1990	4,899		20	245	245	2,572	32
33	IMPROVEMENTS			1991	9,582		20	479	479	4,551	33
34	IMPROVEMENTS			1992	2,610		20	131	131	1,112	34
35	IMPROVEMENTS			1992	2,224		20	111	111	944	35
36	TOTAL (lines 4 thru 35)				$ 154,093	$ 290		$ 6,642	$ 6,352	$ 104,948	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			1993	10,250		20	513	513	3,847	9
10	CABLE REPAIR			1993	848		20	43	43	322	10
11	CABLE REPAIR			1993	250		20	13	13	97	11
12	WINDOW SAFETY CABLES			1993	1,437		20	72	72	540	12
13	LAUNDDRY MOTOR			1993	1,000		20	50	50	375	13
14	IMPROVEMENTS			1994	5,835		20	195	195	1,267	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 19,620	$		$ 886	$ 886	$ 6,448	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE I # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 525,044	$ 102,386	$ 52,017	$ (50,369)		$ 153,569	37
38	Current Year Purchases	60,438	13,413	3,881	(9,532)		3,881	38
39	Fully Depreciated Assets	720,486					720,486	39
40								40
41	TOTALS	$ 1,305,968	$ 115,799	$ 55,898	$ (59,901)		$ 877,936	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT CARE	1984 VAN	1990	$ 1,100	$	$	$		$ 1,100	42
43										43
44										44
45										45
46	TOTALS			$ 1,100	$	$	$		$ 1,100	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 7,095,022	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 136,722	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 101,539	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (35,183)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,836,079	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER
0040592
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CHEVY CHASE CORP	488,855	96,665	48,894	(47,771)	133,514
NUCARE ALLOCATION	36,189	5,721	3,123	(2,598)	20,055
CHEVY CHASE ASSOC					
TOTALS	525,044	102,386	52,017	(50,369)	153,569
LINE 29: CURRENT YEAR					
CHEVY CHASE CORP	52,753	11,907	3,448	(8,459)	3,448
NUCARE ALLOCATION	7,685	1,506	433	(1,073)	433
CHEVY CHASE ASSOC					
TOTALS	60,438	13,413	3,881	(9,532)	3,881
LINE 30: FULLY DEPRECIATED					
CHEVY CHASE CORP					
NUCARE ALLOCATION					
CHEVY CHASE ASSOC	720,486				720,486
TOTALS	720,486				720,486
TOTALS (Should Tie to Totals on Page 13)					
CHEVY CHASE CORP	541,608	108,572	52,342	(56,230)	136,962
NUCARE ALLOCATION	43,874	7,227	3,556	(3,671)	20,488
CHEVY CHASE ASSOC	720,486				720,486
TOTALS	1,305,968	115,799	55,898	(59,901)	877,936

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NUVISION HOLDINGS, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1977	322	10/16/98	$ 1,772,689			3
4	Additions	ALLOCATION FROM NUCARE			14,235			4
5		CHEVY CHASE ASSOCIATES			(1,772,689)			5
6								6
7	TOTAL		322		$ 14,235 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/16/98
Ending 12/31/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 1,713,924
13.	/2002	$ 1,713,924
14.	/2003	$ 1,713,924

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 17,779 Description: NuCare allocation $9,277; Copy machine $6,219; Cylinder Rental $(217); Tank Rental $ 2,500.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1998 JEEP CHEROKEE	$ 506.25	$ 6,600	17
18					18
19					19
20					20
21	TOTAL		$ 506.25	$ 6,600	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM: [ ]
- IN OTHER FACILITY: [ ]
- COMMUNITY COLLEGE: 120
- HOURS PER AIDE: 120

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM: 80
- IN OTHER FACILITY: [ ]
- HOURS PER AIDE: 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 594	$ 892	$	$ 1,486
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)	2,192	3,289		5,481
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 2,786	$ 4,181	$	$ 6,967
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,967			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 237,377	$		$ 237,377	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			275			275	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			17,670			17,670	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				121,954		121,954	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-1		15,394		47	65,667		15,394 65,714	13
14	TOTAL			$ 15,394		$ 255,369	$ 187,621		$ 458,384	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	11,686
2	Lab and X-ray	29,047
3	Urological	1,325
4	Air Beds	2,623
5	Enternal Feeding	20,986
6		
7		
8		
9		
10		
		65,667

	Outside Therapies (Column 5 - Other)	Amount
1	NuCare Services Allocation	47
2		
3		
4		
5		
6		
7		
8		
9		
10		
		47

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,780,662		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,046		6
7	Other Prepaid Expenses	46,293		7
8	Accounts Receivable (owners or related parties)	1,801,356		8
9	Other(specify): See supplemental schedule	6,861		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,752,218	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	838,183		15
16	Equipment, at Historical Cost	534,058		16
17	Accumulated Depreciation (book methods)	(411,946)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	79,135		22
23	Other(specify): See supplemental schedule	700		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,040,130	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,792,348	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 946,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	142		28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	294,762		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,409		31
32	Accrued Real Estate Taxes(Sch.IX-B)	248,627		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	31,952		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	451,084		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,996,889	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,996,889	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,795,459	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,792,348	$ #REF!	48

*(See instructions.)

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSI# 0040592 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Employee Advances	6,861	
	6,861	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Utilities	24,014	
Accrue Expense	282,070	
Due to Affiliates	145,000	
	451,084	

OTHER NON CURRENT ASSETS:		
Deposit	700	
	700	

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER# 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,328,527	1
2	Restatements (describe):		2
3	Schedule attached	4,851	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,333,378	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	607,081	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(145,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 462,081	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,795,459	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CHEVY CHASE CORP. d/b/a CHEVY	# 0040592	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		2,333,378
Adjustments:		
		-
		-
		-
Prior Year Private Pay R & B Income		(4,851)
Total adjustments		(4,851)
Balance - Beginning of Year		2,328,527
Equity(Deficit) from Page 17 Col 1		2,795,459
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		2,795,459

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NI # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,322,321	1
2	Discounts and Allowances for all Levels	(459,769)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,862,552	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	443,029	6
7	Oxygen	4,710	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 447,739	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	329,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,788	20
21	Other Medical Services	66,204	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 416,566	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,665	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,665	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,687	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,730,209	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,933,428	31
32	Health Care	3,548,491	32
33	General Administration	2,499,529	33
	B. Capital Expense		
34	Ownership	2,464,743	34
	C. Ancillary Expense		
35	Special Cost Centers	500,159	35
36	Provider Participation Fee	176,778	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,123,128	40
41	**Income before Income Taxes (line 30 minus line 40)****	607,081	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 607,081	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEV # 0040592 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Misc. Income - Copying (Adjusted out on Page 5A)	268
2	Misc. Income - Jury Duty (Adjusted out on Page 5A)	103
3	Misc. Income - Telephone (Adjusted out on Page 5A)	313
4	Misc. Income - Food Rebate (Adjusted out on Page 5A)	127
5	Misc. Income - Gas (Adjusted out on Page 5A)	743
6	Gain on Disposition of Assets	133
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,687

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,215	3,303	$ 118,564	$ 35.90	1
2	Assistant Director of Nursing	335	477	13,232	27.74	2
3	Registered Nurses	31,282	36,229	680,316	18.78	3
4	Licensed Practical Nurses	46,833	50,860	809,996	15.93	4
5	Nurse Aides & Orderlies	160,788	171,647	1,219,162	7.10	5
6	Nurse Aide Trainees	913	913	5,481	6.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,666	7,596	56,454	7.43	8
9	Activity Director	1,835	2,091	28,032	13.41	9
10	Activity Assistants	12,143	11,124	85,639	7.70	10
11	Social Service Workers	10,485	13,721	119,179	8.69	11
12	Dietician	3,915	4,431	71,668	16.17	12
13	Food Service Supervisor					13
14	Head Cook	6,588	7,322	68,775	9.39	14
15	Cook Helpers/Assistants	27,916	29,341	187,059	6.38	15
16	Dishwashers					16
17	Maintenance Workers	4,581	4,878	86,729	17.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,578	1,644	71,367	43.41	20
21	Assistant Administrator	2,471	2,625	72,464	27.61	21
22	Other Administrative	835	870	37,735	43.37	22
23	Office Manager					23
24	Clerical	14,711	16,103	222,176	13.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	586	607	6,370	10.49	28
29	Resident Services Coordinator	5,152	6,042	105,896	17.53	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,760	4,363	49,158	11.27	31
32	Other Health Care(specify)					32
33	Other(specify)	3,837	3,961	57,216	14.44	33
34	TOTAL (lines 1 - 33)	350,425	380,148	$ 4,172,668 *	$ 10.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 11,104	1-3	35
36	Medical Director	MONTHLY	32,910	9-3	36
37	Medical Records Consultant	MONTHLY	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	5,394	10-3	39
40	Physical Therapy Consultant	93	4,638	10a-3	40
41	Occupational Therapy Consultant	61	3,062	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	50	10a-3	43
44	Activity Consultant	37	1,780	11-3	44
45	Social Service Consultant	56	2,975	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	248	$ 65,945		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 640	10-3	50
51	Licensed Practical Nurses	24	792	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	40	$ 1,432		53

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salary - adjusted out on Page 5	1,165	1,289	$ 41,822	$ 32.45
Home Office Allocation Therapy Aides	2,672	2,672	15,394	5.76
	3,837	3,961	$ 57,216	$ 14.44

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE N # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BARBARA CASEY 03/02-12/31/00	Administrator	0	$ 71,367
DAVID HARTMAN 01/01/-03/01/00	Asst. Administrator	0	25,526
MIKE RAMEL 03/02-12/31/00	Asst. Administrator	0	46,938
FARHAT SHARIF 01/01-12/31/00	VP of Operations	0	37,735
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 181,566

B. Administrative - Other

Description	Amount
Management Fees - NuCare Services	$ 776,238
Network Fees - CarePath	47,884
TOTAL (agree to Schedule V, line 17, col. 3)	$ 824,122
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various - see attached	Legal	$ 10,185
Frost, Ruttenberg & Rothblatt	Accounting	70,457
SAS Architect	Architect	142
Personnel Planners	Unemployment Consultant	4,462
Horizon Healthcare Technology	Computer	4,880
Power Software Development	Computer	8,997
Fox River Foods	Computer	495
AOL Online Services	Computer	175
Health Data System Inc.	Computer	6,703
Purchasing Plus	Purchasing	1,200
UHF Purchasing	Purchasing	48
A&R Security	Security	46,247
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 153,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,988
Unemployment Compensation Insurance	12,051
FICA Taxes	301,667
Employee Health Insurance	164,293
Employee Meals	57,316
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	8,908
Payroll Taxes Reimbursed	19,371
Employee Benefits	43,405
Union Pension	27,526
TOTAL (agree to Schedule V, line 22, col.8)	$ 731,525

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	35,846
Health Care Worker Background Check	4,258
(Indicate # of checks performed 535)	
Yellow Page Advertising	3,315
Promotional Advertising	46,315
Dues and Subscriptions	13,135
License, Inspections and Permits	3,062
Allocation from NuCare	4,251
Allocation from CarePath	908
Less: Public Relations Expense	(519)
Non-allowable advertising	(46,315)
Yellow page advertising	(3,315)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 60,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,121
Alloc. From NuCare	1,463
Alloc. From CarePath	35
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,619

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSIN(# 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	07/95	$ 4,733	3	$ 1,578	$ 788	$	$	$	$	$	$	$
2	HVAC Repair	07/95	8,267	3	2,756	1,377							
3													
4													
5													
6													
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20	TOTALS		$ 13,000		$ 4,334	$ 2,165	$	$	$	$	$	$	$

Facility Name & ID Number CHEVY CHASE CORP. d/b/a CHEVY CHASE NURSING CENTER # 0040592 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. $11,705 IL Council of Long Term Care

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 12,324 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? X YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Chevy Chase Nursing Center, #0034892, 07/01/94

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 176,778
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 57,316 Has any meal income been offset against related costs? NO Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of line 14
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw